U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

From: Social Security Administration Telephone No.

Employer's Name and Address

Date:

Employee's Name:

Employee's Social Security Number:

Claimant's Name:

Claim Number:

Dear Sir/Madam:

We need the following information regarding the above claimant. Please answer the questions below, sign and date this letter and return it in the enclosed envelope.

You may call _____ at the above telephone number if you have any questions.

Sincerely,

Office Manager

---

1. Is (or was) the claimant covered under an Employer Group Health Plan? Yes _____ No _____

2. If Yes, give the original date the coverage began. _____ mm/yyyy

3. Has the coverage ended? Yes _____ No _____

4. If Yes, give the date the coverage ended. _____ mm/yyyy

5. When did the employee work for your company?

   From _____ mm/dd/yyyy To _____ mm/dd/yyyy Still employed _____

Signature and Title of Company Official Date Telephone Number

---